Home Health

Selected Annotated Bibliography

May 1980

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Health Care Financing Administration
Health Standards and Quality Bureau

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HOME HEALTH CARE

Introduction

Weston La Barre, in his sociological treatise, The Human Animal, stressed the crucial importance of the psychosocial factor in health care:

> Prevention and restoration are only part of the overall responsibility of health and medical care. To neglect the interpersonal competency of the individual within his family is in effect to thrust him prematurely into the deterioration and final stage of his life. Attrition can result as surely from emotional wear and tear as from physical accident or failure.

Recently there has been an increase in interest and demand for home health care on the part of the American public. Several circumstances have brought this about. The elderly population is growing not only numerically but also proportionally.

In 1900, only about 4 percent of the nation's total population was over 65. Today, about 10 percent are elderly, and by the year 2000, 12.5 percent or 30.6 million people will be over 65.

There have been many revelations recently of unhealthy conditions in nursing homes. Medicare and Medicaid costs have spiralled. The cost of institutional care has increased. The number of patients who wish to remain at home in familiar surroundings has grown to approximately 85 percent.

Chronic disability, requiring supportive care of indeterminate length, occurs three to eleven times more frequently to the elderly; the poor elderly are twice as likely to become functionally disabled than those who are better off financially.

The Discursive Dictionaryof Health Care provides a definition of home health care from the government's point of view:

> ...health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA), home health agency, hospital or other organized community group. They may be quite specialized or comprehensive (nursing services, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services). Under Medicare, such services must be provided by a home health agency. Under Medicaid, States may, but do not have to, restrict coverage of home health care to services provided by home health agencies.

A movement toward Federal support of home health services was begun in the 1962 social services amendments to the Social Security Act, and titles XVIII and XIX of the 1965 law provided some funding for home health services including "...to the extent permitted in regulations, part-time or intermittent services of a home health aide."

According to a report by a Senate subcommittee on long term care:

> ...if home health services are readily available prior to placement in a nursing home, there is convincing evidence to conclude that such care may not only postpone but possibly prevent more costly institutionalization. What is particularly appealing from the standpoint of the elderly is that home health services can enable them to live independently in their own homes, where most of them would prefer to be.

The subcommittee reached this conclusion after 15 years of study of long-term care. Reimbursement for home care services has greatly broadened their availability.

The movement to expand health care services has until recently been impeded by the medical profession's tendency to place priority on care for acute illnesses and by government's (perhaps not unjustified) fear that if it allows more reimbursement for home health care, patients' families will cut back on the services they are presently performing and the financial support they are providing; and hospitals, needing to keep beds filled to keep costs down, may have a tendency to neglect informing qualified patients of the availability of home health services. There has also been the problem of how to ensure proper review of home care programs.

This bibliography contains articles and discussions covering everything from trends, policies, costs, and evaluation of home health care to alternative placement and terminal care. For the convenience of the reader, an index has been prepared listing articles under each major subject category.

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SUBJECT INDEX

PSRO Document Control Resume

ACCESSION NUMBER	70542

Daubert EA

A SYSTEM TO EVALUATE HOME HEALTH SERVICES

Nursing Outlook 25:3, Mar 1977, 168-71

To assure the quality of health care services, a patient care review system was developed by the Visiting Nurse Association of New Haven, Connecticut. This article describes a system in which patient care audit records are assessed on the basis of criteria for evaluating home health care. The definition of quality of care is derived from the standards of care as stated in the written policies of the agency. The process of record review is carried out by the Patient Review Committee. The review form is designed to assess three dimensions of care: admission to service, delivery of services, and discharge from service. Criteria for each item, such as care plan, medication test, and physician orders, are described and defined in the instruction sheet, and the assessment is made on the basis of actual evidence in a patient's record that the criteria have been met. At present the system is working in the sense that it answers the question, "Does a patient receive good care?" To demonstrate that home health agencies do benefit the patient, future efforts will have to be focused upon adding outcome criteria to the review procedure so that the system will become process-outcome method of evaluation. (KKH)

Standards, Norms and Criteria;

Patient Care Team; Medical Audit; Care Criteria; Home Care Services; Quality Assurance; Connecticut; Visiting Nurse Association; Evaluation Methodologies;

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PSRO Document Control Resume

ACCESSION NUMBER: 20567

Mims RB
Thomas LL
Conroy MV

PHYSICIAN HOUSE CALLS: A COMPLEMENT TO HOSPITAL-BASED MEDICAL CARE

Journal of the American Geriatrics Society 25:1, Jan 1977, 28-34

ABSTRACT: A physician-oriented, hospital-based Home Care Program (HCP) is described. The staff includes a director, resident physicians, nurses, social workers, and clerical personnel. House calls are made by resident physicians during off-duty hours, but the patients, their families, and other health professionals may help with their care. Drugs, equipment and supplies are available through the hospital and contract vendors. The most common medical diseases are cardiac and cerebrovascular disorders, arthritis, diabetes mellitus, chronic pulmonary disorders and hypertension. Of 513 patients evaluated in one year, 337 were admitted to the HCP. Two-thirds were women. Ages ranged from 18 to 106 (median, 68 years). Under the HCP there was significant improvement and control of the medical problems, and a decrease in hospital and emergency room admissions, and clinic visits; 207 of the 337 patients were discharged. The HCP cost less than other outpatient and inpatient services. It proved to be a rewarding, economical and effective means of improving medical care for a metropolitan population dependent upon hospital-based physicians for medical services.

Health Care Facilities and Services;

Home Care Services; Home Care Programs (HCP); House Calls; Cost Effectiveness; Level of Care; Primary Health Care; Long Term Care; Medical Services; Treatment; Therapeutic Equivalency;

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DATE 4/77

PSRO Document Control Resume

ACCESSION NUMBER	70601

AN- 70601
Au- Munger B
Ti- HOSPITAL-HOME HEALTH CARE
So- Hospital Forum 19:11, Apr 1977, 15+

The realization that the home environment can facilitate the healing process prompted two Albuquerque hospitals, St. Joseph Hospital and Presbyterian Hopsital Center, to begin planning a program of Hospital-Home Health Care. This would be a non-profit agency that would provide comprehensive, coordinated home health care to the homebound patient under the direction of the attending physician, with heavy emphasis on teaching the patient self-care to encourage early rehabilitation. The program should include a whole range of supportive services instead of just nursing care, and the program would serve patients of all ages. The program's income would be provided through Medicare/Medicaid, insurance payments and reimbursement from patients. In addition, the concept would be a major cost containment effort, since home health care can provide appropriate care for som hospitalized patients, and the cost of home care is much less than hospital or home nursing care. Hospital-Home Health Care is a service that meets the needs of many patients, in an efficient and economic manner, and contributes to early discharge of hospital patients.

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PSRO Document Control Resume

ACCESSION NUMBER	70666

CITATION

Rossman I

OPTIONS FOR CARE OF THE AGED SICK

Hospital Practice 12:3, Mar 1977, 107-16

Our health care system is biased toward premature admission of elderly patients to hospitals and nursing homes. Experience indicates, however, that institutionalization poses such a high risk of adverse psychological and physical reactions for the geriatric patient that it may be counter-productive even for major illnesses. A number of steps can be taken to mitigate the negative potential of necessary hospitalization: improved communication, sympathetic attention, and adaptation of hospital routines to compensate for the patient's fragility. Outpatient alternatives should be available and used for a given patient whenever medically feasible. Operating programs at Montefiore Hospital in New York City and certain other programs illustrate the following options, such as home care, after care, day care, and specialized housing. (TJK)

Statistics, Demography; Health Care Facilities and Services;

Aged; Ambulatory Care; Home Care Services; Professional-Patient Relations; Treatment; Hospital Departments; Hospitalization; Patient Care Team; Comprehensive Health Care; Montefiore Hospital, New York City; New York; Psychological Factors;

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ACCESSION NUMBER: 70815

CITATION

AN- 70815
Au- USDHEW, Health Resources Administration, National Center for Health Statistics, Division of Health Resources Utilization Statistics
Ti- NATION'S USE OF HEALTH RESOURCES
So- USDHEW, Health Resources Administration, National Center for Health Statistics, Division of Health Resources Utilization Statistics 1976, 104 pp
CA- Statistics, Demography
Health Care Facilities and Services
Kw- Health Resource Factors (t)
Hospital Outpatient Clinics
Hospitals (t)
Hospitalization (t)
Nursing Homes
Mental Health Services
Home Care Services (t)
Ambulatory Care Facilities
Hospitals, Acute Care
Long Term Care
Mi- DHEW Pub. No. (HRA) 77-1240

ABSTRACT

For a generation at least, those concerned with care for the chronically ill have maintained that whenever possible the patient's own home should be utilized for extended care rather than the institutional setting, which is too often depersonalized.

Given a disease or disability that is relatively stable in its course and given a responsible "other person" within the home to render basic care, personal care and most medical services for the patient can be brought into the home rather than the patient being moved from his own familiar surroundings into some institutional facility. These services may be provided by physicians, physician assistants, nurses, therapists, and other similar types of personnel.

Organizations have been created in many areas of the country to provide for the augmentation of home care by furnishing needed equipment and supplies and specialized personnel on an as needed basis. These are usually termed comprehensive home care programs or services and may be sponsored or operated under a variety of auspices, i.e., hospitals, community nursing agencies, local health departments, and the like.

In addition to such organized programs, the United States has had a long tradition of community based home nursing services, homemaker services, "meals-on-wheels," and other similar services to enable the maintenance and support of chronically ill, aged, disabled or infirm persons within their home settings. This section attempts to reflect the extent to which such services now exist.

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ACCESSION NUMBER: 70943

AN- 70943
Au- Russell DL
Ti- HOME HEALTH CARE -- ANOTHER WAY TO REDUCE COSTS?
So- Pennsylvania Medicine 80:9, Sep 1977, 19-23

Demands by the American people and their Congress for control over the runaway cost of health care has caused physicians, hospitals, and governmental agencies to search for ways to cut costs and increase efficiency of health care facilities. In 1975 the Pennsylvania Department of Health's Advisory Council for Comprehensive Health Planning created a Home Health Care Committee to develop standards and guidelines for comprehensive home care services in the state. A Home Care Information Consortium, sponsored by Community services of Pennsylvania has designed informative materials in order to clarify the state's status and needs and to increase public awareness of home care services. A major problem of home care as a component of a comprehensive health plan is that third party payment for most services may be obtained only through physician referral and many doctors do not know how or where to refer patients--even when home care is suitable for a patient. The well-being of the individual should be the main goal of all agencies and services working to provide home care, whether they provide medical, social, recreational, nutritional, or other services. Essential components of home care are: teaching self-care; securing necessary equipment and supplies; instructing the family members in the physical case of the individual, and helping the family to cope with the problems resulting from the illness or disablement. Payment for home care is similar to that for other types of care--they may be covered by Medicare or Medicaid, third parties such as Blue Cross, commercial insurance plans, the Veterans Administration, United Way agencies, or local government agencies such as Area Agencies on Aging. Many home care agencies give care beyond the limits of insurance coverage if the needs persist.

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PSRO Document Control Resume

ACCESSION NUMBER	71027

AN- 71027
Au- Joint Commission on Accreditation of Hospitals
Ti- QUALITY REVIEW BULLETIN 10/77 AMBULATORY CARE
So- Quality Review Bulletin 3:10, Oct 1977, 32pp

A statewide organization representing home health care agencies, the Pennsylvania Assembly of Home Health Agencies (PAHHA) was founded in 1970. One of the highest priorities of the PAHHA was to encourage development of standards that would enhance the quality of home health care services by insuring uniformity of care in urban and rural areas. To meet this priority, the PAHHA in conjunction with three other groups — the Western Pennsylvania, Susquehanna Valley, and Greater Delaware Regional Medical programs — began a statewide quality assurance program in 1974. Called the Pennsylvania Assembly Project, this quality assurance program was a two-year voluntary experiment. The 31 participating home health care agencies differed in many respects. The typical agency, however, was community-based and voluntary in structure. Providing two to four different services to patients, the typical agency depended primarily on Medicare and Medicaid programs for reimbursement. Most home health care was rendered to a semirural, geriatric population in the lower-middle socio-economic class.

Perhaps the most tangible result of the project was development of criteria sets that suggested optimal patient outcomes. Variations in compliance to criteria identified a need for practitioners to articulate goals of visits. As a result of the audits, agency inservice programs were conducted to share criteria with staff personnel, outline goals of visits to patients with certain health problems, and describe the type of data necessary to show compliance with criteria. In some agencies, improved record systems, such as the problem-oriented medical record, were instituted to cope with the documentation problem.

Project findings encouraged many agencies to begin ongoing inservice educational programs related to identified learning deficiencies of practitioners. Other agencies responded to audit findings by updating policies and procedures to conform with advances in disease prevention and clinical management. Realizing that accurate patient histories enhance the quality of services provided, several agencies reported attempts to establish better coordination of information with acute care facilities.

Although the Pennsylvania Assembly Project ended in 1976, a number of agencies that participated have continued to meet regularly. The project helped to establish guidelines for ongoing quality assessment activities by these agencies. To share their experience with home health care workers in other states, some project participants have conducted workshops. These quality assurance efforts should help home health care to survive as a valuable part of the nation's total health care delivery system. ■

(excerpt from article)

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PSRO Document Control Resume

ACCESSION NUMBER	80035

CITATION

Hellinger FJ

SUBSTITUTABILITY AMONG DIFFERENT TYPES OF CARE UNDER MEDICARE

Health Services Research 12:1, Spr 1977, 11-8

ABSTRACT

The question of whether Medicare coverage of outpatient services, nursing home care, and home health care reduced the use of short-term hospitals by Medicare beneficiaries, and whether reduced hospital use saved the Medicare program money, is reexamined by use of a simultaneous-equations model estimated by the two-stage least-squares method. It is argued that all alternative modes of care must be examined simultaneously for accurate results. The findings partly support and partly contradict results of previous studies: both outpatient care and nursing home care can substitute for hospital care, but a complementary relationship between outpatient and nursing home care indicates that the additional coverage resulted in greater, not less, expenditure by Medicare. (author abstract)

Finance, Economics; Health Care Facilities and Services;

Medicare; Ambulatory Care; Nursing Homes; Statistical Analysis; Home Care Services; Utilization, Health Facility; Cost Prediction; Hospitals, Acute Care;

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DATE 11/77

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ACCESSION NUMBER	80047

CITATION

Hackley JA

FULL-SERVICE HOSPICE OFFERS HOME, DAY, AND INPATIENT CARE

Hospitals 51:21, Nov 1, 1977, 84-7

ABSTRACT

The Hillhaven Foundation of Tacoma, Washington, an affiliate of a nursing home group, has developed a comprehensive hospice program in Tucson, Arizona, that provides terminal cancer patients with inpatient care, home care, day care, and if necessary a 12-month bereavement service for the family. The Hillhaven Hospice gives palliative and supportive care on a 24-hour, 7-day-per-week basis, in collaboration with the patient's physician. The emphasis is on symptoms control. These services are available to residents of the Tucson metropolitan area; referral can be made by the patient, his family or his physician. The hospice is a community-oriented program of care: home care is provided by the Tucson Visiting Nurse Association during working hours, and by the hospice team during evenings and weekends; emotional and psychological support is provided by the Tucson East Mental Health Center. The hospice is licensed by the state as a skilled nursing facility and is applying for a license as a "special hospital-hospice". It is one of three such institutions in the United States being considered for contracts by the National Cancer Institute to support program development and evaluation. Based on outstanding community acceptance, Hillhaven expects to be self-supporting within three years. (LP)

Health Care Facilities and Services; Health Care Assessment;

Hospice; Terminal Cancer; Hillhaven Hospice, Tucson, Arizona; Tucson, Arizona; Arizona; Home Nursing; Hospitalization; Patients; Intermediate Care Facility;

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PSRO Document Control Resume

ACCESSION NUMBER	80104

AN- 80104
Au- Lashof, JC
Ti- DO BENEFITS EXCEED COSTS OF ALTERNATIVES TO INSTITUTIONAL CARE?
So- Geriatrics 32:11, Nov 1977, 33, 36
Ca- Health Care Facilities and Services
Kw- Long Term Care (t)
Nursing Homes
Home Care Services (t)
Costs and Cost Analysis (t)
Health Services Research (t)
Benefits

As the elderly population increases and more people of all ages with chronic health problems survive longer, public decision makers will be under increasing pressure to expand or reorganize long term care assistance programs. HEW contracted a series of experiments and demonstrations in order to provide valuable information on which to base long-range policy decisions on alternative means of reimbursement to hospitals and alternatives to institutional care such as day care, day hospitalization, and homemaker services.

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PSRO Document Control Resume

ACCESSION NUMBER	80183

AN- 80183
Au- Berkoben RM
TI- HOME HEALTH CARE AND QUALITY ASSURANCE: THE EXPERIENCE OF THE PENNSYLVANIA ASSEMBLY PROJECT
So- Quality Review Bulletin 3:10, Oct 1977, 25-8
Ca- Standards, Norms, Criteria
Health Care Facilities and Services
Health Care Assessment
Kw- Home Care Services
Outcome Approach
Quality Assurance
Guidelines
Care Criteria
Diabetes Mellitus (d)
Nursing Audit (t)
Patient Care Management

The Pennsylvania Assembly of Home Health Agencies (PAHHA) began a two year statewide program in 1974, to insure a uniform quality of home health care in both urban and rural areas and thereby to reduce inappropriate hospitalization. Criteria were developed for optimal patient outcomes. All regional agencies completed studies on the same topics, focusing on diseases most often encountered and using the same criteria. Variations in compliance with the criteria indicated the need for practitioners to outline the goals of their visits to patients. Documentation was the major deficiency. For example, in the audit of diabetes mellitus, evidence of compliance with the criterion relating to the patient's ability to administer insulin was repeatedly missing. Many agencies failed to see that a patient's understanding of his disease is an important indicator of quality care. In some agencies needed equipment, such as blood pressure apparatus and urine testing kits, was not available. Many agencies expanded their efforts at in-service education to correct the deficiencies of practitioners, updated their procedures to conform with advances in disease prevention, and improved their record systems. The quality assurance efforts of this project should help home health care to continue as a valuable part of the total health care system. (LP)

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ACCESSION NUMBER	80195

AN- 80195
Au- Schultz PR
McGlone FB
Ti- PRIMARY HEALTH CARE PROVIDED TO THE ELDERLY BY A NURSE PRACTITIONER/ PHYSICIAN TEAM: ANALYSIS OF COST EFFECTIVENESS
So- Journal of the American Geriatrics Society 25:10, Oct 10, 1977, 443-6
Ca- Manpower
Finance, Economics
Kw- Ambulatory Care
Primary Health Care (t)
Aged (t)
Cost Effectiveness (t)
Nurse Practitioners (t)
Physicians
Professional Practice Patterns
Home Care Services
Nursing Homes
Mi- Reprints from Phyllis R. Schultz, Div. of Geriatrics, Medical Care and Research Foundation, 1565 Clarkson St. Denver, CO 80218

. An experimental design was used to compare the delivery of primary care by two health manpower patterns—the Physician Only (PO) and the Adult Health Nurse Practitioner/Physician (NP/P) Team. The study group consisted of 167 patients in three subgroups (Ambulatory, Homebound, and Nursing Home). The dependent variables were effectiveness and efficiency. Effectiveness was measured by the Goal Attainment Scale. Efficiency was determined by measuring the operational use and cost of the primary and supportive systems for health care delivery. A cost-effectiveness model was used to facilitate the comparison between the two approaches to primary care. Scientific hypotheses related the measures of the dependent variables to the levels of the independent variable. The conclusions of the study were: 1) The NP/P Team is as effective as the PO but substantially more efficient in its operational use of the systems for health care delivery; 2) Ambulatory patients can make a positive change in the achievement of their health care goals with efficient use of the health care system, if they receive their care on a PO basis; 3) Homebound patients can make a positive change in such achievement if they receive their care from a NP/P Team; and 4) Nursing Home patients can make a positive change in such achievement whether they receive their care from the PO *or* from the NP/P Team.

(Abstract from article)

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PSRO Document Control Resume

ACCESSION NUMBER	80233

CITATION

Colt AM
Anderson N
Scott HD, Zimmerman H

HOME HEALTH CARE IS GOOD ECONOMICS

Nursing Outlook 25:10, Oct 1977, 632-6

A recent study has found that home maintenance services reduce Medicaid and state medical assistance costs by decreasing the incidence and duration of institutional care. Many elderly patients with chronic disabilities and limited normal function can be maintained at home at about one-third the cost of institutional care. A study of two programs was made to determine the demand for services, their effectiveness, and their costs. The programs provided each patient with a professional nursing assessment visit every two weeks, a home health aide visit two to four times a week, and a therapist or social worker if needed. Utilization data indicate that both programs kept patients out of institutions even though for some patients it was only a matter of delay. The average patient for whom institutional care was prevented saved over 80 days of institutionalization. In both programs 36% of all patients who avoided institutional care would have had their care chargeable to public reimbursement programs. Third party insurers should explore the financing of home maintenance as a less costly alternative. Table 5 follows with a comparison of costs. (LP)

Health Care Facilities and Services; Finance, Economics;

Home Care Services; Insurance, Health; Home Nursing; Cost Control; Extended Care Facilities; Cost Effectiveness; Third Party Payment; Medicaid; Utilization, Health Facility;

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PSRO Document Control Resume

ACCESSION NUMBER: 80366

AN- 80366
Au- Lewis PM
Ti- HUP ABSTRACT SYSTEMS FOR LONG-TERM CARE
So- Medical Care 14:5 Supplement, May 1976, 202-8
Ca- Data Processing
Kw- Hospital Utilization Project (HUP)(t)
Long Term Care (t)
SNF
UHDDS
Rehabilitation
Home Care Services
Data Gathering
Forms
Health Data Systems (t)
Information Needs
Medical Records
Data Processing

The Hospital Utilization Project (HUP) has developed systems for data collection, report generation, and program analysis for three long-term care components. In the Skilled Nursing Facility Program, a uniform medical record abstract was developed, a procedure manual prepared, and instruction provided to participating SNFs both in abstract completion and report interpretation. Reports have been found useful for utilization review, medical care evaluation, facility management, and community health planning.

The Rehabilitation Facility Program abstract includes basic data consisting of elements of the Uniform Hospital Discharge Data Set modified for the rehabilitation setting, and an optional functional status section. Designed to meet the needs of medically oriented facilities, the program should have great potential if administrative and staffing problems in the facilities relating to the provision of data can be overcome, and if difficulties regarding uniformity in defining and displaying primary diagnosis for summary reports can be resolved.

The primary objectives of the Home Health Agencies Project were development of utilization review methods and data on patient care in the home health setting. The major obstacle encountered was that record systems and methods of statistical reporting in the participating agencies are so varied and fragmented as to make meaningful conclusions and comparisons almost impossible at this stage.

(Abstract from the article)

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ACCESSION NUMBER	80481

Iglehart JK

LONG-TERM HEALTH CARE--THE PROBLEM THAT WON'T GO AWAY

National Journal 9, Nov 5, 1977, 1725-27

A February study by the Congressional Budget Office projects significant increases in the long-term care population and in the costs of providing such care. Cost constraints and disclosures of fraud in the nursing home and home health agency industries have made lawmakers wary of voting expanded benefits. Abuses have been documented in probes by the Senate Special Committee on Aging, the New York State Moreland Act Commission, and by several House subcommittees. The Federal emphasis on assuring adequate income for the elderly rather than the availability of necessary services is being challenged. New policies under consideration in Congress include revising Medicare and Medicaid restrictions on non-institutional services, eliminating financial need as a basis for eligibility, and developing a comprehensive long-term care grant program. HCFA has plans to test various approaches. A list of Federal programs providing funds for long-term-care services is appended. (TJK)

Legislation, Regulations;

Long Term Care; National Health Policy; Medicare; Aged; Fraud; HCFA; Nursing Homes; Financing, Government; Home Care Services; Medicaid; Health Expenditures; US Congress; Federal Regulation;

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PSRO Document Control Resume

ACCESSION NUMBER	80483

Brickner P
Scharer LK

HOSPITAL PROVIDES HOME CARE FOR ELDERLY AT ONE-HALF NURSING HOME COST

HCFA Forum 1:2, Nov-Dec 1977, 7-12

The number of elderly Americans is increasing, as is the cost in Federal dollars of institutional care for the aged. The level of State and Federal funding in 1977 for nursing homes was $5.6 billion; funding for home health care during the same period totalled $356 million. This description of a home health care program operated by St. Vincent's hospital in New York City supports the contention that home care is a viable alternative to institutionalization. A team consisting of a coordinator, physician, nurse, social worker, and homemaker work together to locate, contact, and provide follow-up care for aged community residents. The total living cost per patient per year in this home health program is $8,539; the cost for similar patients in New York nursing homes is $16,231. Tables giving cost breakdowns are included in the article. (KML)

Health Care Facilities and Services; Finance, Economics;

Home Care Services; Nursing Homes; Cost Effectiveness; Cost Control; Financing, Government; Aged; Long Term Care; New York;

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AVAILABILITY Reprints from: Dr. Brickner 153 West 11th Street New York, NY 10011	COMMENTS/SPECIAL INSTRUCTIONS ON USE
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PSRO Document Control Resume

ACCESSION NUMBER	80583

AN- 80583
Au- Comptroller General of the United States
Ti- REPORT TO THE CONGRESS: HOME HEALTH -- THE NEED FOR A NATIONAL POLICY TO BETTER PROVIDE FOR THE ELDERLY
So- U.S. General Accounting Office, Dec 30, 1977, 55pp
Ca- Health Care Facilities and Services
Kw- Home Care Services (t)
National Health Policy (t)
Aged (t)
Special Report
Nursing Homes (t)
Costs and Cost Analysis
Institutional Economics

This report discusses the cost of providing home health care to the elderly, including the value of services provided by family and friends, by level of impairment as compared with the cost of nursing home care. The report also discusses the estimated cost of certain proposed legislative changes for liberalizing home health benefits under Medicare and the need for a national policy to better provide for the elderly where the services of families and friends are not available.

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PSRO Document Control Resume

ACCESSION NUMBER: 80744

Mitchell JB

PATIENT OUTCOMES IN ALTERNATIVE LONG-TERM CARE SETTINGS

Medical Care 16:6, Jun 1978, 439-52

The purpose of this study was to compare health status outcomes in three alternative long-term care settings in the Veterans Administration: 1) home care; 2) community-based nursing home care; and 3) hospital-based nursing home care. Patients were measured on a behavioral index of health status, at two points in time: when transferred from the acute care hospital to one of the three treatment programs (pretest and three months later (posttest). Since patients could not be randomly distributed to programs, two methods were employed to control for potential sample selection bias: the choice of a nonequivalent control group design, and multivariate analytic techniques. First, within each program type, patients were randomly selected from both a hospital that offered only that program as a long-term care alternative and from a hospital that provided all three treatment settings. Second, multiple regression analysis was used to control for pretest differences among patients. Patients placed in the home care program displayed the greatest mean improvement in functional health status, holding all other variables constant. This treatment effect was not uniform, however; patients showed differential rates of improvement across the three programs, based upon both initial health status and prognosis.

(Abstract from the journal)

Health Care Assessment;

Long Term Care; Hospitals, Veterans; Home Care Services; Home Nursing; Hospital Nursing Service; Patient Care Planning; VA; Outcome Approach; Research; Nursing Homes; Extended Care Facilities; Statistical Analysis;

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PSRO Document Control Resume

ACCESSION NUMBER	80806

AN- 80806
Au- Mitchell JB
Ti- ALTERNATIVES IN EXTENDED MEDICAL CARE -- A COMPARATIVE STUDY OF POST-ACUTE TREATMENT PROGRAMS IN THE VETERANS ADMINISTRATION
So- Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, MA, Jul 1976, 119pp
Ca- Health Care Facilities and Services
Kw- Hospitals, Veterans (t)
VA
Treatment
Home Care Services (t)
Nursing Care (t)
Intermediate Care Facility (t)
Extended Care Facilities
Community Health Services
Long Term Care
Patient Care Management
Patient Care Planning
Mi- Available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106, UM no. 77-15, 273

Various treatment programs for chronically ill patients in Veterans' Administration hospitals who require extended medical care are compared. Three programs are studied: hospital-based home care (HBHC), community nursing home care (CNH), and intermediate care (IC) within a Veterans' Administration facility. It was hypothesized that a hospital with multiple treatment options places its extended care patients more appropriately and successfully than hospitals with only a single available treatment choice, that patients in community-based programs are more successful than patients in institutional settings, and that patients in different programs will show differential rates of improvement as a function of initial level of disability and prognosis. Questionnaires to obtain data on social and medical characteristics and functional status were utilized, and a followup questionnaire was administered 3 months later or when treatment was terminated. Multiple regression was the primary technique employed in data analysis. It was determined that patients who enter an extended medical care program from a multiprogram hospital will not always show greater mean improvement in physical functioning than patients from other hospitals. While the treatment effect of the CNH program was slightly superior to the IC program, the HBHC program was superior to both programs. The implications of the findings for long-term care policy development are discussed. The study forms are appended, and a bibliography is included.

(Abstract from Health Planning, Jul 4, 1978)

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PSRO Document Control Resume

ACCESSION NUMBER: 80855

AN- 80855
Au- Widmer G
Brill R
Schlosser A
Ti- HOME HEALTH CARE: SERVICES AND COST
So- Nursing Outlook 26:8, Aug 1978, 488-93
Ca- Health Care Facilities and Services
Kw- Home Care Services (t)
Costs and Cost Analysis (t)
Urban Population
LOS
Patients
Reimbursement

Recent concern about the increasing costs of health care has directed attention to an established, but still underused, alternative—the home, an institution in its own right. There have been many reports documenting the extraordinary costs of institutional care, as well as the inappropriate use of nursing homes and long-term care facilitites.[1-3] While some articles have been written postulating the cost effectiveness of care at home and the barriers to expansion of home care services, and studies have been made on limited aspects of home care or specific home care populations, little objective data are available to determine the total costs of home care services, how they are used, and how they are reimbursed.

In a unique partnership, the Visiting Nurse Service of New York and the New York City Health Systems Agency conducted a study of home care during 1975-76 in one district in New York. The study, which was funded by the Regional Medical Program, had three major objectives: (1) to obtain information about patients needing home health care and their utilization of home health care services when all barriers to services, such as cost, were removed, (2) to arrive at a reasonably accurate estimate of the cost to the patient and to third party payors of the services needed to maintain the patient at home; and (3) to obtain information about the types and amounts of reimbursement now available to defray the costs.

Although the study deals with services in one urban setting, we believe the findings have significance for planners, health care providers, and legislators concerned with a health care delivery system that is both economical and responsive to changing population needs.

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PSRO Document Control Resume

ACCESSION NUMBER	81024

AN- 81024
Au- Ricker-Smith K
Trager B
Ti- IN-HOME HEALTH SERVICES IN CALIFORNIA: SOME LESSONS FOR NATIONAL HEALTH INSURANCE
So- Medical Care 16:3, Mar 1, 1978, 173-90
Ca- Health Care Facilities and Services
Kw- Utilization, Health Facility (t)
Patient Need Assessment
Cost Control
Home Care Services (t)
Medicare
Medicaid
Long Term Care (t)
NHI
Diagnosis
Community Health Services
Reimbursement
California (g)
Professional Practice Patterns
Mi- Available from: Long Term Care Research Project, Program of Biostatistics Department of Biomedical and Environmental Health Science, School of Public Health, University of California, Berkeley, CA

Spiralling Medicare and Medicaid expenditures, recent revelations about unhealthy conditions in nursing homes, and pressure for national health insurance have led to increased interest in in-home health services as appropriate and cost-effective. Medicare and Medicaid provided some stimulus for development of in-home health services. Shortly after these programs went into effect, however, major policy decisions were made aimed at curbing utilization of in-home health services. California home health data for 1966–1973 document the effects of major policies that led to the development and decline of in-home health services under Medicare and Medicaid. A review of those policies, supported by the California data, indicate that in-home health services have been greatly restricted by historical underdevelopment and legislative and regulatory emphases. In addition, the study indicates the limitations of the kind of data currently collected and suggests data requirements necessary for future program evaluation and planning in home health.

(Abstract from Journal)

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PSRO Document Control Resume

ACCESSION NUMBER 81027

McNamara EM

CONTINUING HEALTH CARE: ATTENTION TURNS TO DAY CARE AND HOSPICE SERVICES

Hospitals 52:17, Apr 1, 1978, 79-80+ Hos

Continuing health care, as used in this review, can encompass care offered at any point in a continuum of medical care. The literature this year has emphasized care of the aging, largely to the exclusion of children and young adults. The needs of the terminally ill have also received much attention through descriptions of the hospice concept. Day care and day hospitals are being discussed as promising alternatives, although problems such as reimbursement and transportation remain to be resolved. Efficient home care programs have been described, but questions have also been raised about cost comparisons and payment gaps. Discharge planning plays an important role in continuing health care. Aspects considered in 1977 included patient self-determination, the provision of supportive services in the home, and telephoning services such as Tele-Care. Attempts to create linkages among the various providers of continuing care have met with barriers in differing goals and management styles. (EB)

Health Care Facilities and Services;

(4)

Comprehensive Health Care; Community Health Services; Outreach; Home Care Services; Level of Care; Long term Care; Nursing Care; Patient Need Assessment; Extended Care Facilities; Nursing Homes;

(71)

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PSRO Document Control Resume

ACCESSION NUMBER	81045

Tolkoff-Rubin NE
Fisher SL
O'Brien JT, Rubin RH

COORDINATED HOME CARE: THE MASSACHUSETTS GENERAL HOSPITAL EXPERIENCE

Medical Care 16:6, Jun 1978, 453-4

The problem of post-hospital care remains a continued challenge, as many patients who no longer require expensive acute care facilities continue to occupy these beds, awaiting appropriate placement. The Massachusetts General Hospital Coordinated Home Care program, under the central administration of the Boston Visiting Nurse Association, has demonstrated that home care can be a viable, economically feasible alternative to institutionalization for carefully selected patients, when the appropriate medical and social needs can be met. Three major groups of patients have been effectively cared for: 1) patients with multi-system chronic illness; 2) patients with terminal malignancies; and 3) patients with catastrophic neurologic disease. The organization of the Coordinated Home Care program, the criteria for patient selection, and the issue of funding are reviewed. The impact of this program is examined in terms of its potential for better utilization of the Massachusetts General Hospital facilities, as well as the more appropriate coordination and use of existing health care resources in the community.

(Abstract from the journal)

Health Care Facilities and Services;

Home Care Services; Patient Care Planning; Long Term Care; Length of Stay; Hospitals, Acute Care; Massachusetts; Financing, Organized; Massachusetts General Hospital; Cost Effectiveness; Disability Evaluation; Comprehensive Health Care;

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PSRO Document Control Resume

ACCESSION NUMBER	81135

AN- 81135
Au- Beringer GR
Hardman JR
Ti- OFFERING CONTINUITY OF CARE FOR THE ELDERLY
So- Hospital Progress 59:9, Sep 1978, 38+
Ca- Health Care Facilities and Services
Kw- Comprehensive Health Care (t)
Aged (t)
Home Care Services
Hospitals, Acute Care
St. Benedict Hospital and Nursing Home, San Antonio, TX
Cost Effectiveness (t)
Nursing Homes
Day Care
Patient Care Planning
Level of Care (t)
Texas (g)

St. Benedict Hospital and Nursing Home provides a continuum of patient care services for the elderly ranging from home health services to acute hospital care. The many levels of care provided result in the advantages of economy of scale for the organization and continuity of care for the patients.

(Abstract from journal)

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PSRO Document Control Resume

ACCESSION NUMBER	81252

AN- 81252
Au- Davidson RC
Ti- FUTURE OF HOME HEALTH AGENCIES
So- Journal of Community Health 4:1, Fall 1978, 55-66
Ca- Health Care Facilities and Services
Kw- Attitude to Health
Program Evaluation
Home Care Services (t)
Voluntary Workers
Los Angeles, CA
Patient Care Team
VNA of Los Angeles, CA
California (g)
Task Performance and Analysis (t)
Preventive Health Services
Health Education
Primary Health Care
Patient Care Management
Insurance, Health
Health and Welfare Planning (t)
Referral and Consultation
Financing Mechanisms

A multidisciplinary, multi-institutional, volunteer task force was convened by the Visiting Nurse Association (VNA) of Los Angeles to perform an evaluation of the agency and, on the basis of the evaluation, to make recommendations regarding the future potential of home health service agencies in the United States.

For the VNA of Los Angeles, this use of a voluntary task force as a planning mechanism was successful; we strongly recommend its application to other agencies. The recommendations made were specific to the VNA of Los Angeles, but many are applicable to home health agencies in general. They called for an expansion of the types of services currently offered, with an emphasis on the coordinated team approach to health problems, an increased emphasis on preventive and health education services, and a movement toward providing services to groups as well as individual home care patients. The task force also urged willingness to expand services to include primary care. Modern management techniques were recommended as tools to increase the efficiency of home health service agencies. Potential new sources of revenue were proposed.

(Abstract from journal)

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PSRO Document Control Resume

ACCESSION NUMBER	81256

AN- 81256
Au- Belinkoff D
Ti- HEALTH CARE FOR OLDER VETERANS
So- Congressional Record 124:68, Part VI, Oct 14, 1978, 5658-60, 5702-3, 5812-3
Ca- Health Care Facilities and Services
Kw- Evaluation Methodologies
Peer Review
Regional Medical Programs
Delivery of Health Care
VA (t)
SNF
Comprehensive Health Care (t)
LTC
Pre-Admission Certification
Length of Stay (t)
Nursing Homes
Health and Welfare Planning
Personal Care Home (PCH)
Home Care Services
Ambulatory Care
Aged (t)
HSRO (Health Services Review Organization)

The Veterans' Administration (VA) has established an admirable record in providing comprehensive health care to those who have served in the United States armed forces over the past 110 years. As the VA plans to expand medical services to meet the needs of the coming decades there is growing concern over the increasing number of elderly veterans who like all senior citizens will require a greater amount of acute and long-term care as they become more infirm.

Exactly what services and which facilities call for expansion, however, is subject to debate. Assessments differ as to the VA's role in geriatric health care, depending on the priorities that are set and the predictions that are made regarding the future of national health insurance.

The purpose of this paper is to outline and discuss the services available to the elderly veteran and review the criticisms of them, to assess VA policies which affect the elderly, to suggest the issues which demand further investigation by Congress and to make policy recommendations.

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PSRO Document Control Resume

ACCESSION NUMBER	81265

AN- 81265
Au- Talerman M
Ti- OVERSIGHT HEARING ON HOME HEALTH AGENCIES
So- Selected Information Services V:10, Sep 19, 1978, 1-2
Ca- Health Care Facilities and Services
Kw- Home Care Services (t)
Costs and Cost Analysis (t)
Medicare
Congressional Hearings
Reimbursement (t)
Guidelines
Fraud

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81265

SUBCOMMITTEE HEARING ON HOME HEALTH CARE SERVICES

Expenditure for home health services under Medicare has increased dramatically in recent years -- from $287 million in 1976 to $786 million in 1979; and it continues to rise. The major contributing factor in the continuous cost increase seems to be the lack of guidelines for reimbursement of these services. This problem, as well as the role of the intermediaries, alternative modes of providing home health care services, and Federal spending practices were some of the major issues aired at the hearing of the Oversight Subcommittee of the House Ways and Means Committee, August 10, 1978. Representative Sam M. Gibbons (D-Fla.), presided.

In his opening remarks, Congressman Gibbons stated that home health care was of great value to the patient, provider, and the intermediary; but the wide disparity in adminstrative costs in the agencies, and fraud and abuse in the home health care industry must be controlled. The subcommittee is considering more definite cost reimbursement guidelines for the Medicare program, revision in home health care agencies' cost reporting procedures, and development of review criteria for home health service claims.

Gregory Ahart, Director of the Human Resources Division, General Accounting Office, pointed out that the lack of explicit program regulations contributed to the large variation in costs of services reimbursed by Medicare. This was substantiated by an audit of home health agencies, intermediaries, and Medicare Bureau headquarters. In spite of the concerns expressed by intermediaries and medicare regional representatives, HEW has not defined "costs which are substantially out of line." The intermediaries seem to have difficulty in applying the principle of "reasonable cost" as it now stands. Ahart said there is an urgent need for a national recognition of the "reasonable-costs issues" for home health agencies, and for policies to alleviate this situation.

Merritt W. Jacoby, Acting Senior Vice President, Blue Cross Association, explained that Blue Cross Association serves as an intermediary for over 2,000 home health agencies, and processes approximately 85 percent of the total HHA Medicare cost reports. He encouraged the development of alternatives in providing home health care services, and he supported home health care as a cost effective alternative to institutionalization. The demand for these services has created a surge of new agencies in the country, and chain organizations consisting solely of HHAs, management companies, and HHA consultants have sprung up. Jacoby emphasized the responsibility to protect the interests of the Medicare program and the taxpayer, and at the same time to assure the HHA its proper reimbursement for Medicare related costs.

To accomplish this end, he suggested that a national program for reimbursement be established to:

- Identify potential abusive conditions and to focus on the intermediary's activities in these areas of investigation;
- Set uniform definitions, criteria, and procedures within which the HHA providers and the intermediaries could operate, e.g., identify costs which are "substantially out of line";
- Set national education programs for HHAs and intermediaries on these criteria.

Hadden Hall, Executive Director of San Francisco Home Health Service, claimed that although laws have been enacted to "prevent, postpone and reduce the need for institutional care," they have not significantly improved the range and utilization of home health services for the consumer.

The major problems hindering the delivery of home health care services are ill-defined regulations governing the amount and the methods of reimbursement, and fragmented audit responsibility from the Federal to local levels.

Hall maintained that the situation could be improved if a national policy to support the development of comprehensive home health services is introduced, and Mediplan funding continued.

Hall recommended regulations to help control fraud and abuse:

- Providers who refuse to cooperate with proper authorites should be suspended;
- Providers participating in one Title (XVIII, XLX, XX) should be required to provide services under the other Titles and for the public at large:
- Intermediaries should provide consumers with a copy of bills received;
- Cost reports for Medicare and Medicaid should be standardized.

HCFA Administrator Robert Derzon reviewed the progress made in home health reimbursement procedures and outlined the actions needed to improve services. He explained that although there has been an increase in expenditures, a substantial portion can be attributed to normal growth factors, such as an increase in the number of beneficiaries and an increase in the demand for home health benefits. However, the size of such increases in expenditures warrants a closer study to determine the influence of inappropriate utilization of home health services.

Derzon felt that many of the criticisms leveled at regulations governing costs actually arise from the unscrupulous activities of only a few operators in health agencies who "want to get rich at the expense of the public." For example, newly organized private and not-for-profit HHAs in Florida and elsewhere have attempted to claim unnecessary and unreasonable operating costs in their Medicare reports. (Usually these agencies restrict their service to Medicare patients.) This increased expenditure for Medicare home health benefits in states with a large number of "100 percent Medicare" home health agencies forced HCFA to re-examine the procedures for reimbursement. To reduce fraud and abuse, HCFA has increased Medicare budget allocations for audits of HHA intermediaries in areas of the country where elderly residents are concentrated. HCFA may also prohibit an agency from limiting its services solely to Medicare benefits.

The consensus of those who testified was that a concerted effort should be made to establish a uniform set of definitions, criteria and reporting procedures; this is basic to an overall improvement in the Medicare program's approach to HHA reimbursement.

Mia Talerman

PSRO Document Control Resume

ACCESSION NUMBER	81303

AN- 81303
Au- Weller C
Ti- HOME HEALTH CARE
So- New York State Journal of Medicine 78:12, Oct 1978, 1957-61
Ca- Health Care Facilities and Services
Kw- Cost Effectiveness
Comprehensive Health Care
Level of Care
Home Care Services (t)
Access to Service
Quality Assurance
Demand for Services
Professional Practice Patterns
Societies, Medical
Utilization, Health Facility
Patient Care Teams

It has been recently stated that home health care is a system whose time has arrived. Physicians and county medical societies should support the development and expansion of sound home-care programs and urge that they be covered under both private and public programs. There is no doubt that they can aid selected patients, reduce costs, reduce institutionalization, and provide valuable assistance to physicians who participate in them. The effective use of home health-care services can only be realized when well-designed criteria for selection of patients for home care and standards for evaluating the effectiveness of home care are used. The success or failure of coordinated home health-care programs is dependent on physician support and participation.

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ACCESSION NUMBER	81309

Solomon DK
Baumgartner RP
Weissman AM, Briscoe ME, Smith RM, McCormick WC

PHARMACEUTICAL SERVICES TO IMPROVE DRUG THERAPY FOR HOME HEALTH CARE PATIENTS

American Journal of Hospital Pharmacy 35:5, May 1978, 553-8

A 12-month study was conducted with a home health care service agency based at a rural community hospital to identify specific problems associated with drug therapy of home health patients and to evaluate the contributions made by the pharmacist to patients' drug therapy. The majority of those served by the agency were geriatric patients and had multiple chronic diagnoses. The following services were provided by the pharmacist to patients and staff: (1) maintenance and surveillance of comprehensive patient medication profiles, (2) attendance at daily multidisciplinary conferences where therapy and progress of patients were discussed, (3) recommendations on drug therapy and (4) drug information. Information collected by the pharmacist in home interviews of 46 patients was evaluated. Analysis of subjective data revealed that, more than any other prescription drug categories, analgesics were overused while bronchodilators and antibiotics were underused. Prior to the visit of the pharmacist, less than half of the patients reported receiving oral information concerning their medications. Evaluations by attending physicians and nurses confirmed the need for continued pharmacist involvement with the home health service. As a result of the study, a role model is outlined for pharmacists serving home health care agencies. (Abstract from the journal)

Manpower; Health Care Facilities and Services;

Pharmacists; Pharmaceutical Services; Home Care Services; Aged; Clinical Competence; Utilization, Drug; Drug Therapy; Rural Health Services;

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ANALYST tjk

DATE 10/78

90009
National League for Nursing
TYPE, LENGTH, AND COST OF CARE FOR HOME HEALTH PATIENTS
National League for Nursing, Council of Home Health Agencies, Community Health Services, 1975, 15pp

There is an urgent need for information concerning the type, length, and cost of different kinds of care for various home health patients. Home health agencies have traditionally kept ongoing statistics on number of patients and visits, classified by age and diagnosis, but have not been able, except in a few agencies, to relate this information to total care provided per patient. In the summer of 1973, under the auspices of NLN's Council of Home Health Agencies and Community Health Services, a group of directors from ten large voluntary and combination agencies began a series of informal meetings to discuss vital problems related to the delivery of home health services. As a result of their concern, a special study was begun to provide answers to such crucial questions as: How can agencies conducting home health programs define and cost the unit of service they offer? How do they describe the range of services utilized by the patients? What is the anticipated number of days on home care for various types of patients? This monograph is a report of that study.

90047
Joint Commission on Accreditation of Hospitals
ACCREDITATION MANUAL FOR HOSPITALS
Joint Commission on Accreditation of Hospitals, Chicago, IL, 1978, 233p

The hospital that provides home care services shall coordinate the effective provision of physician-directed medical, nursing, and related health care services of high quality in the home. The objectives of the hospital-administered home care program and the scope of services provided shall be specified and documented. As a minimum, the hospital-administered home care program shall provide at least professional nursing and one other therapeutic service. The home care program shall be provided with administrative and medical direction and with a sufficient number of qualified personnel to deliver patient care services and meet program objectives. The home care program shall be guided by appropriate written policies and procedures. The administrative and professional activities of the home care program shall be documented. The quality and appropriateness of home care services rendered shall be reviewed and evaluated regularly to determine the effectiveness of such services in meeting the objectives of the program.

From: Joint Commission on Accreditation of Hospitals, Publication Department, 875 North Michigan Ave., Chicago, IL 60611; $20.00

90293
Davidson SV
COMMUNITY NURSING CARE EVALUATION
Family and Community Health 1:1, Apr 1978, 37-55

Home health care agencies have been established to provide skilled nursing care for homebound patients who do not need the care provided in a hospital. This paper examines the development of review activities in these agencies, discusses the rationale for quality assurance in nursing, outlines the components of a quality assurance program, and sets forth the aspects of nursing care evaluation in a home health agency. The objective of the study in a home health care agency is to assure that nursing care services are timely and appropriate to the needs of the patient. The critical requirements of an NCE study in the community health care setting include: 1) objective criteria accepted by the nursing staff, against which the actual performance is measured; 2) utilization of non-nursing personnel for time-consuming tasks that do not require clinical judgements; 3) full documentation and recording of the topic, method, and results of the nursing care evaluation study. The criteria must be flexible to promote individual initiative and clinical advancement; and the NCE study must lead to a logical course of action suited to any needs identified in the study. The process of the NCE study is circular: audit, corrective action, re-audit. For its own NCE studies, a home health agency should adopt a form that is effective and easy to implement. Examples are included. Several levels of functions of NCE personnel (practitioners, supervisors, and directors of nursing) are identified. (ACM)

00013
Lack SA
Buckingham RW
FIRST AMERICAN HOSPICE: THREE YEARS OF HOME CARE
Hospice, Inc., New Haven, CT, 1978
From: Dept of Public Information, Hospice, Inc., 765 Prospect St, New Haven, CT 06511; $15.75 prepaid
Not in clearinghouse collection

The Hospice at New Haven, Connecticut, provides home care services for terminally ill patients and their families. The program satisfies the following objectives: maintenance of the family unit, relief of loneliness and separation anxiety, and symptom control for maximum comfort and alertness. The home care services are supplemented by a 44-bed facility. The first section of this report reviews the Hospice's history and details its organizational and administrative structure. Detailed analysis of the characteristics of hospice patients and their families comprise the second section. The final chapters present highlights of a research study evaluating the effects of hospice care. Hospice patients and persons providing their primary care exhibited less anxiety, depression, hostility, somatization, friction, submission and dependence than non-hospice patients. They also showed greater satisfaction in social and leisure activities and relationships with extended families. An interesting observation was the greater effect of hospice services on primary care persons than on patients. Although the results of this study are limited, they might serve as an incentive for more conclusive subsequent studies of terminally ill patients and their families. (BOR)

00018
Kleczkowski BM
Mach EP
Thomas RG
SOME REFLECTIONS ON CONTAINING THE RISING COST OF MEDICAL CARE UNDER SOCIAL SECURITY
Social Science and Medicine 13C:1, 1979, 21-32

The health insurance that forms part of many social security schemes in industrialized countries works in two ways to exert a steady upward push on medical care costs: (1) by making care ever more available at little or no direct cost to the consumer, it increases demand for services more rapidly than supply; (2) by being too often considered as simply another way of paying for existing kinds of medical care without providing incentives for changing to less expensive, more rational methods, it helps perpetuate the existing bias towards the more costly kinds of treatment and does not strike at the root of increasing costs. To help contain costs, social security administrators are asked in this article to consider: (i) revised structures of benefits that would accord at least equal treatment to outpatient, home care, prepaid group practice, and other effective but less costly alternatives to hospitals and private practitioners; (ii) better cost accounting to permit more accurate measurement of the relative costs of different kinds of care; (iii) selection of appropriate medical technologies and manpower; (iv) measures to increase cost-consciousness of physicians and the public; (v) various ways to contain the cost of drugs; (vi) promotion of a guided self-care; (vii) for the long run the authors examine the role of preventive medicine in cost containment. (Abstract from the journal)

00029
Weissert WG
LONG-TERM CARE: AN OVERVIEW
US, National Center for Health Services Research, Dec 1978,
from the publication Health: United States - 1978

Long-term care includes a wide array of services offered in a variety of settings to individuals with differing needs and preferences. The increase in the percentage of the total population over 65, along with government legislated financing mechanisms, spurred the growth of institutional facilities which provide long-term care. Many factors determine the quality of care provided by these facilities. Several studies have identified community accountability as a major determinant; those nursing home residents having community visitors who act to protect the patients' quality of care generally receive better care. Appropriate placement of patients also contributes to quality of care, emphasizing the need for formal alternatives to institutional care. A long-term care continuum of services, one which recognizes care needs as varied and changing and not limited to those provided in traditional settings, can provide patients with options offering different care packages in various settings. Services could be designed to take advantage of community, family, and visitor involvement, and provide a broader array of placement choices. Alternative methods to institutional care currently in use include: adult day care centers, home health services, homemaker services, and hospices. The movement to alternatives assumes that most long-term patients want to be independent and self-sufficient and that most families prefer to provide their own long-term care if they can receive supportive services. More research on these assumptions is needed, as well as into improving existing facilities, providing alternatives, and the cost-benefits of both. (BOR)

00058
Smits H
Draper P
CARE OF THE AGED: AN ENGLISH LESSON?
Annals of Internal Medicine 80:6, 1974, 746-53

A comparison of the services provided for the elderly in Great Britain and the United States shows the impact that organized medical care has on day-to-day clinical activities. The British have made many advances in geriatrics despite multiple problems that can often be traced to the three-part administrative structure of the National Health Service (NHS). The recent debate on the design of a new NHS administration raises questions that should concern Americans. Institutions designed to pay for and monitor health care need the flexibility and sensitivity to respond to innovations in the rapidly changing and very personal field of medical science. Issues such as the mechanisms for control both by consumers and providers should be considered when evaluating the many health care bills now before the United States Congress.

00150
White KW
HOW THE PRIVATE SECTOR IS FIGHTING HEALTH COST INFLATION
Aging, May/Jun 1979, 16-20

The most serious problem confronting the nation's health care system continues to be health cost inflation. Rising health care costs are, of course, part of a larger dilemma, with the price tag of everything going up from housing to energy to food to education. In general, concerned groups within the private sector--and these encompass employers, labor unions, private health insurers, hospitals, the medical profession, and consumer groups--are undertaking programs with real potential for slowing the rate of inflation. These include: (1) Programs to carefully review physicians' fees, hospital charges, and use of health services. (2) Incentives to encourage preventive care to help keep people well, and to provide more services outside the hospital, when this is medically possible. (3) Involvement in community health planning to bring health care needs and resources into a better balance. (4) Experimenting with new ways of reimbursing hospitals. (5) Encouraging alternatives to paying physicians on a fee-for-service basis. (6) Health education and promotion programs to motivate people to adopt healthier life styles.

00209

Rafferty LJ

ADULT DAY CARE: ITS EFFECT UPON THE PSYCHOSOCIAL QUALITY OF LIFE OF OTHERWISE-HOMEBOUND OLDER PERSONS IN AN URBAN SETTING

Long Term Care and Health Services Administration Quarterly 3:3, Sep 1979, 221-29

This study sought to determine whether regular participants of the Willows and Wilder Adult Day Care Program in the St. Paul, Minnesota Model Neighborhood differ significantly from homebound older persons residing in that agency's target service areas with regard to the degree of life satisfaction and social interaction they experience. Identical interviews designed to determine social indicators for life satisfaction and social relationships were conducted with both groups of participants. The scores of the adult day care participants were consistently higher with respect to social relations and activities. The study also indicated that the day care respondents had more positive feelings about their activities. In addition, they were involved to a greater degree in social relationships. The study's results supported earlier studies which had found an associational relationship between social interaction and morale. The scores for the life satisfaction indicator were higher for the adult day care participants. Although it was noted that care should be taken in making generalizations from this targeted study, it was recommended that planners and providers of human services strongly consider adult day care as a vehicle with which to offer social interaction and physical rehabilitative services to persons traditionally difficult to reach. (BL/DGS)

00236
Holmes D
Holmes M
Steinbach L, Hauser T, Rochleau B
THE USE OF COMMUNITY-BASED SERVICES IN LONG-TERM CARE BY OLDER MINORITY PERSONS
Gerontologist 19:4, 1979, 389-97

Telephone interviews were conducted with all of the home health, homemaker, daycare and meal providers (205) in 32 counties selected to represent the upper decile of counties in terms of minority proportion of one of the four Federally-recognized minority groups. Seventy percent of the agencies serve a proportion of older minority persons which is at least commensurate with the proportion of minority persons in the county. Agencies which serve a proportionate share of minorities differ significantly on a number of variables from agencies which underserve minorities.

00239
Lack SA
HOSPICE: A CONCEPT OF CARE IN THE FINAL STAGE OF LIFE
Connecticut Medicine 43:6, Jun 1978, 367-72

Hospice is a specialized health care program emphasizing the management of pain and other symptoms associated with terminal illness. Hospice makes the family the unit of care, centers much of the caring process in the home, and seeks to enable the patient to carry on an alert and pain-free existence. Pioneered in America by the Connecticut Hospice, and recently endorsed by the American Medical Association, the movement now includes over 200 developing hospices across the United States. Out of the British and New Haven experience have evolved program characteristics essential to the delivery of effective and appropriate care.

00267
Nursing Outlook
HOME HEALTH AGENCIES AND COMMUNITY NURSING SERVICES ACCREDITED BY NLN/APHA, SEPTEMBER 1979
Nursing Outlook 27:9, Sep 1979, 615-16

This article lists the Home Health Agencies and Community Nursing Services that have been accredited by NLN/APHA.

00309
Weissert WG
Wan TTH
Livieratos BB
EFFECTS AND COSTS OF DAY CARE AND HOMEMAKER SERVICES FOR THE CHRONICALLY ILL: A RANDOMIZED EXPERIMENT
US, National Center for Health Services Research, Hyattsville, MD, Aug 1979, 34pp
From: NTIS, 5285 Port Royal Rd, Springfield, VA 22161; NCHSR Research Summary Series; DHEW Publication No (PHS) 79-3250

The study was a randomized experiment carried out by the National Center for Health Services Research to examine the effects of adult day care and homemaker services on a Medicare-eligible population and to assess the impacts of those services on institutionalization and Medicare costs. Differences between experimental and control groups in health outcomes and psycho-social measures also were compared, and patients were identified for whom the new services might prove more effective than existing options. Difficulty in enrolling patients in the program and low utilization rates for some groups of patients may suggest low demand for these services. The study also suggests that for the majority of patients, day care and homemaker services probably served as additional benefits under Medicare, rather than substitutes for nursing home care. Net total Medicare costs (the new services plus existing Medicare services) were 71 percent higher for the day care experimental group and 60 percent higher for the homemaker experimental group. Experimental/control group differences in physical functioning, psychosocial measures, and death rates are also discussed in this article. (Abstract from the document)

00339
US, Comptroller General
REPORT TO THE CONGRESS: HOME HEALTH--THE NEED FOR A NATIONAL POLICY FOR THE ELDERLY
US, GAO, Washington, DC, Dec 30, 1977, 67pp

This report discusses the cost of providing home health care to the elderly, including the value of services provided by family and friends, by level of impairment as compared with the cost of nursing home care. The report also discusses the estimated cost of certain proposed legislative changes for liberalizing home health benefits under Medicare and the need for a national policy to better provide for the elderly where the services of families and friends are not available.

From: US, GAO, Distribution Section, Rm 4522, 441 G St, NW, Washington, DC 20548 US, GAO Publication No HRD 78-19

00583
Rhoads-Warden C
Knowlton J
NURSING HOMES WITHOUT WALLS IN NEW YORK STATE
Perspectives on Medicaid Management, Apr 1979, 5-22

On August 11, 1977, New York's Governor Hugh Carey signed legislation establishing a new program for Medicaid patients--the Long Term Home Health Care Program. This program is designed to provide individuals who need high levels of medical care with an alternative to placement in a skilled nursing or intermediate care facility. Described as the "nursing homes without walls" program by its legislative sponsor, State Senator Tarky Lombardi, the program has attracted considerable interest on part of the Federal government and other States. This article discusses some of the background which led to the legislation, describes the program, and reports on the status of its implementation.

00594
Boyd S
Flatley C
Parks P, Smaller V
FOCUSING ON TRENDS IN LONG-TERM CARE
Hospitals 53:24, Dec 16, 1979, 43, 46

In 1979 there were several important developments in the areas of home and hospice care, mental health, and rehabilitation. The AHA views on cost reimbursement for home health care, and their testimony on the need to remove barriers to reimbursement under Medicare are summarized. Standards for hospice care have been approved by the National Hospice Organization, which is also developing an accreditation process. Moves to bring hospice care within the reimbursement systems of third party payers include a study conducted jointly by NHO, AHA, and the Blue Cross/Blue Shield organizations to identify the appropriate role of hospice care in the health care delivery system. Hospital statistics presented from the annual AHA report highlight the move to more community-based mental health care. In rehabilitation, there is evidence of increased public awareness of available services leading to stepped-up evaluation procedures by the Commission of Accreditation of Rehabilitative Facilities. An assistant secretary has been appointed within the federal government responsible for activities related to the handicapped and disabled. (CRW)

00631
US, Comptroller General
REPORT TO THE CONGRESS: ENTERING A NURSING HOME--COSTLY IMPLICATIONS FOR MEDICAID AND THE ELDERLY
US, General Accounting Office, Washington, DC, Nov 26, 1979, 181pp

This report notes that Medicaid has become the chief support of nursing home care for the chronically impaired elderly and recommends changes in health planning to reduce the overutilization of extended care facilities. It is argued that many elderly patients enter nursing homes because of deficiencies in community health services and health care delivery systems. Medicaid eligibility policies create financial incentives for the elderly to use nursing homes, and Medicaid assessment procedures encourage patients to accept extended institutional care. A Preadmission Screening Program is proposed, with demonstration projects recommended to assess the cost effectiveness of preadmission patient needs assessment, improved community health services, and support for home care services. With this program, health planning will be directed towards providing the elderly with a viable alternative to extended care facilities. (WMY)

00664
Stone JR
Patterson E
Felson L
EFFECTIVENESS OF HOME CARE FOR GENERAL HOSPITAL PATIENTS
Journal of American Medical Association 205:3, Jul 15, 1968, 95-98

A random group of 175 nonindigent patients were placed in home care and the end results of their treatment were compared to those of a balanced control group of 85 patients retained in a general hospital. Follow-up study of patients revealed that end results of care for the two groups of patients were not significantly different regardless of the mode of care. Neither diagnosis nor prognosis made a significanct difference in the end results for patients receiving either mode of care, indicating the acceptability of home care as an alternate to continued hospitalization. Patients and physicians strongly preferred home care, and it proved economically feasible for a private medical insurance carrier to provide coverage. (Abstract from the journal)

00665
Wartski SA
Green DS
EVALUATION IN A HOME-CARE PROGRAM
Medical Care 9:4, Jul/Aug 1971, 352-64

The home care program of the Nassau County Department of Health is described. Various approaches to evaluation of a home care service are given and examples demonstrated. In particular, a functional index, the Barthel Index, with the addition of a mental score, was applied to examine its usefulness in a service of this kind. It was found to be of use in categorizing patients and is of sufficient value to warrant further exploration of this and other evaluation tools in appraising patient programs and appropriateness of distribution of services.
(Abstract from the journal)

00672
Vicker RL
HOSPICE MOVEMENT IN THE UNITED STATES
Long Term Care and Health Services Administration Quarterly 3:4, Win 1979, 253-83

The philosphy of the hospice movement to provide palliative and supportive care to terminally ill patients and their families is a relatively new concept, antithetical to modern American curative medicine, with its emphasis on technology, efficiency, and wellness. While there is still no standard definition of a hospice or what services it should provide, the model program is The Connecticut Hospice, Inc. which now includes an educational foundation and an independent national leadership arm, the National Hospice Organization. There were, in 1978, 59 operating hospice organizations and 73 being developed. An outline of hospice services, staff, and funding methods and costs is provided. Because most hospices emphasize home care and rely heavily on social and community services, administrators face serious problems accomodating its needs and services to existing reimbursement systems. New definitions of "homebound" and "skilled care" are needed. Third party payers are reluctant to support hospice care until standards are established and services defined. Hospice programs must be effectively integrated with total health care facilities, but some services, such as bereavement visits, are properly delivered by social service bureaus. The government has supported demonstration and evaluation projects in hospice care and has recently waived some reimbursement restrictions. The logical extension of the hospice movement would be application of its philosophy to care of the elderly. (MCA)

00706
Demkovich LE
IN TREATING THE PROBLEMS OF THE ELDERLY, THERE MAY BE NO PLACE LIKE HOME
National Journal 51-52, Dec 22, 1979, 2154-58

The proportion of the population over age 65 will increase from its current level of about 11 percent to almost 14 percent by the year 2015. In the face of this anticipated growth, direction of the federal role in long-term care of the elderly is of increasing concern to policy makers. It is generally agreed that while many elderly persons would be happier and healthier if cared for at home, their families have neither the resources nor the time to provide such care. Present public subsidy programs encourage the nursing home model of care which, for many elderly, means watching their assets drained until they are forced to go on Medicaid. The alternative of providing public programs to support community home health care would add an estimated $10 billion to the cost of health services for the elderly. DHEW is currently examining ways to coordinate and expand home health services, including a three- to five-year demonstration project to assess methods of delivering such services. Also under consideration are projects to test different financing arrangements, such as formula grants using Medicaid money and a grant program to fund non-medical alternatives. (CRW)

00772
Franklin Research Center
HOME HEALTH CARE PROGRAMS: A SELECTED BIBLIOGRAPHY
Franklin Research Center, Philadelphia, PA, Jul 1979, 106pp

The annotated bibliography was developed for the nursing community as an aid to planning, managing, and evaluating home health care programs. It will enhance the user's awareness of the scope and diversity of home health care services and will aid nursing and other health professionals to identify the various types of programs available, determine personnel requirements for providers of home care, and determine the types of programs needed in a given community. The nursing component of the National Health Planning Information Center provides health planners with a centralized comprehensive source of information on nurse manpower planning to facilitate an improved health care delivery system in the United States. The component acquires, screens, synthesizes, disseminates, and makes available specialized documentary material on nursing as well as methodological information on a wide variety of topics relevant to health planning and resources development.

From: NTIS, 5285 Port Royal Rd, Springfield, VA 22161 $6.50
Order No HRP-0501101/OWW Abstracted in Health Planning, Dec 4, 1979
Not in Clearinghouse Collection

00872
US, Bureau of Health Manpower
HOME HEALTH CARE PROGRAMS: A SELECTED BIBLIOGRAPHY
US, Bureau of Health Manpower, Hyattsville, MD, 1979, 97pp

This tenth volume in the Nurse Planning Information Series includes citations of books, journal articles, government and research reports, and bibliographies relating to home care programs. It is intended for use by health planners, including nurse planners, educators, administrators, researchers, and practitioners. The citations are divided into five sections: planning, administration, and management; community health; education; evaluation; and health information systems. Abstracts are included where available. (CRW)

Series: Nurse Planning Information Series DHEW Pub No HRA 79-60

00965
Colvin BM
Nelson JF
HOME HEALTH CARE IN NEW YORK STATE: A DESCRIPTIVE ANALYSIS
Home Care Association of New York State, Inc, Syracuse, NY, May 1979, 142pp

This study examined a stratified random sample of patients in home health agencies in New York State to identify characteristics, needs, treatments, costs, and the availability of services. The majority of home health agency patients were female, widowed, white, released from a hospital to home care and did not live alone. The medical and physical problems of these clients were those generally associated with the problems of older people. Half the patients had physical disabilities, and over 70 percent had severe enough problems to be eligible for health related and skilled nursing care. The majority of directly supplied services involved nursing, physical therapy, and home health aide services. Support services arranged by the community agencies included equipment and supply services, clinical and technical diagnostic services, transportation services, and personal support services including friendly visitors, meals-on-wheels, and pastoral services. About half of the patients studied improved, while about half deteriorated. The average episode of home health care cost $642; most of the costs were paid by Medicare or Medicaid, with less than five percent of patients paying directly for the services they received. (WMY)

01086
US, Health Care Financing Administration
HOME HEALTH AND OTHER IN-HOME SERVICES: TITLES XVIII, XIX, AND XX OF THE SOCIAL SECURITY ACT
US, Health Care Financing Administration, Baltimore, MD, 1979, 105pp

Public Law 95-142, the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, requires the Department to review current programs for home health services, assess the status and problems of in-home services generally, and propose changes for improving present conditions. This mandate covers Medicare, Medicaid, and Social Services, of the Social Security Act, and nearly all aspects of home health and other in-home services, including eligibility criteria; scope and definition of services; coordination among programs; reimbursement methods; criteria for provider participation; management issues, including prevention of fraud and abuse; and quality assurance. Home health and other in-home services incorporate a range of services from skilled nursing, therapy, and personal care to home-making, chore services, and financial counseling. In-home services may be viewed in two different contexts: one as a follow-up of limited duration to a relatively short-term institutional stay and the other as on-going services to a chronically disabled population which might postpone or prevent long-term institutionalization. We are aware that it is a concern of some members of Congress, interest groups, and specialists in the field of aging and long-term care that present programs providing health and social services in home settings and present methods of financing such services are not adequate to meet the need for long-term home health care. It is in this context that the Department has addressed itself to the issue of home health and other in-home services. (Summary from document)

01148
Manber MM
HOSPITAL BACKLOG: PATIENTS WITH NO PLACE TO GO
Medical World News 21:8, Apr 14, 1980, 63-65, 69-70, 77, 81

According to government officials, physicians, and nursing home and hospital spokesmen, the major elements in the backlog problem are a combination of what nursing homes consider unsatisfactory reimbursement for Medicaid and Medicare patients and a shortage of nursing home beds. As the chief support of nursing home care for elderly people who can't manage on their own, Medicaid pays nearly half the nation's $15.7 billion nursing home bill. A report issued last November by the General Accounting Office summarized succinctly how federal policies push the use of nursing homes rather than community services: Medicaid, Medicare, and other public programs provide little or no financial coverage for long-term care in the community; Medicaid, however, offers full or partial coverage of long-term care in a nursing home. Adding to the problem faced by backlog patients who would rather go home than to a nursing home are the lack of information about long-term care options, fragmented or very few services in the community, widely varying eligibility requirements, and the tendency of professions to recommend nursing home placement because they don't have the expertise and time to arrange for community care. Suggestions as to how to alleviate this situation are given. (KC)

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